MODULE 2: WHEN TERRORISM HAPPENS

With preparedness planning completed, this module moves on to what a disaster mental health worker can expect at the site of a terrorist attack. It explains how terrorism impacts those who experience it directly or indirectly. It describes the "ripple effect" of terrorism, as its intensity subtly spreads and impacts the community's mental health, culture, and economy. This module also describes the phases of recovery from terrorism, the importance of conducting rapid needs assessments, who may be expected to support a response to terrorism, and ways to determine who is in charge onsite. It concludes with a discussion of the roles that a disaster mental health worker may be asked to assume on the site, stories from the field, and guidance from members of the Community Resilience Project (CRP) staff on recognizing one's own strengths and limitations prior to volunteering for onsite duty.

After completing this module, the disaster mental health worker will be able to:

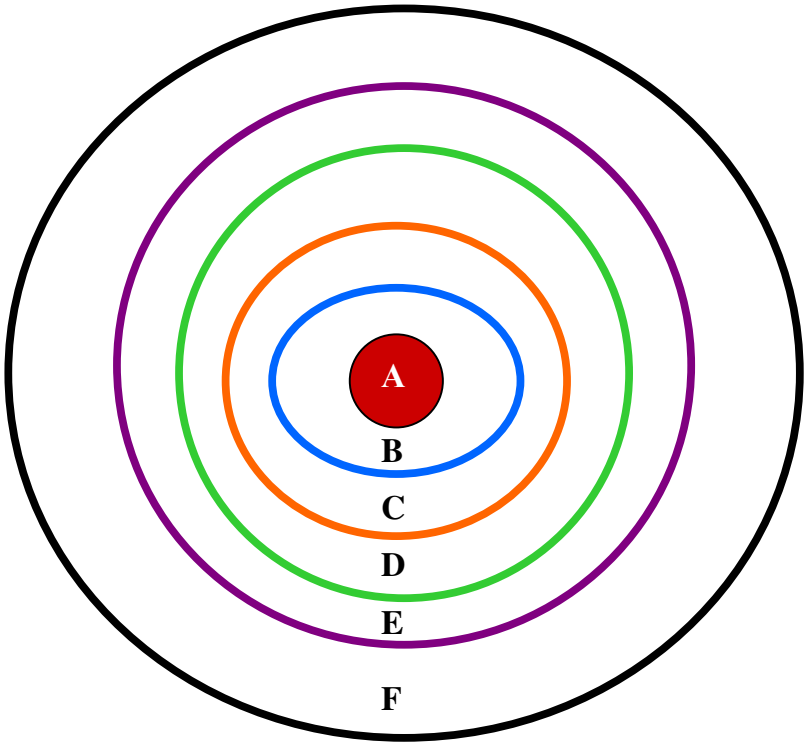
- Understand the "ripple effect" of terrorism on the mental health of individuals and communities
- Recognize the impact of terrorism on a community's culture and economy
- Identify and recognize the phases of recovery from terrorism
- Conduct an onsite assessment
- Identify the roles and responsibilities of the key response agencies at the local, state, and federal levels during a response to terrorism
- Identify the role of the disaster mental health worker onsite

Impact: Recognizing the Ripple Effect

The physical impact of a terrorist event involving mass trauma and casualties is concrete and visible. The psychological victimization, however, is much more subtle in nature, sending waves of shock and distress throughout the community, the state, and often the nation. A population exposure model is used to depict the widespread impact that mass violence has on the various victims, families, responders, and community groups that may be affected. This model,[1] illustrates how the collective social, political, environmental, and cultural impacts of a large-scale community disaster interact with individual reactions and coping strategies. Employing a public health approach to understanding the effects of terrorism, the model provides the disaster mental health worker with a macro-view of the enormity of its impact. Beginning with the reactions of those most directly impacted by the event, the model portrays the "ripple effect" of terrorism; that is, how terrorism echoes to leave nearly everyone affected.

[1]DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Figure 2–1. Population Exposure Model[2]



Key:

A: Seriously injured victims; bereaved family members, loved ones, close friends

B: Victims with high exposure to trauma; victims evacuated from the disaster

C: Bereaved extended family members and friends; rescue and recovery workers with prolonged exposure; medical examiner's office staff; service providers directly involved with death notification and bereaved families

D: People who lost homes, jobs, pets, valued possessions; mental health providers; clergy, chaplains, spiritual leaders; emergency health care providers; school personnel involved with survivors; families of victims; media personnel

E: Government officials; groups that identify with the target victim group; businesses with financial impacts

F: Community at large

[2] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The Population Exposure Model is a useful tool for beginning to assess and understand the needs of the community. There are groups of victims, however, that are not identified or integrated into the model. For example, a significant number of people who experienced a prior trauma, such as a violent crime, terrorism, or war, and were in Northern Virginia on 9/11 demonstrated psychological symptoms from traumatic exposure. Individuals did not have to work at or be located near the Pentagon on 9/11 to be exposed to the trauma and develop trauma-related symptoms. For example, the immigrant populations experienced a growing sense of isolation and backlash from the mainstream community. Members of the Muslim community experienced antagonism and were victims of hate crimes. It is important to look beyond the groups listed in the model and identify all people who are impacted by a terrorist incident and the aftermath.

What surprised me the most was the elongated effect of things, in that, of course, there is the immediate aftermath of 9/11 where people, those directly affected, the victims, the ones that were injured, and of course the families, are affected, but also the community at large. And then, as time marched on, there were more distinctions within the community at large, as to subgroups of the population that were affected, such as immigrants and various ethnicities in our community.

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Individual Reactions to Stress

Stress reactions often surface after people have grappled with their immediate situations. The intensity of the reaction is determined by the magnitude of these life concerns. It also may be influenced by certain characteristics of a terrorist event, such as:

- Threat to life and limb
- Severe physical harm or injury
- Receipt of intentional injury/harm
- Exposure to the grotesque
- Violent/sudden loss of a loved one
- Witnessing or learning of violence toward a loved one
- Learning of exposure to a noxious agent
- Intentional death or harm caused by others

Survivors may be affected in less direct ways, as well. Often terrorist attacks paralyze entire communities and business industries, impacting the financial stability of their residents. Following 9/11, for example, tourism in Northern Virginia and the DC metropolitan area came to a complete halt. The airports were closed, conferences were canceled, and school trips were rescheduled. People working in the tourism, hospitality, and other related industries were affected financially. Once the airports reopened, the travel business resumed, but some

businesses continued to be affected because of the race or ethnicity of the owners or workers. Consider this scenario . . .

> *A taxi driver is relieved to be able to resume his airport route, which before 9/11 generated the most revenue. But he quickly learns that because of his Middle Eastern descent, passengers are refusing to get into his cab. And those who do are sometimes hostile and threaten violence against him and "his people."*

This scenario points out the complexity and nuance of terrorism's impact and the importance of being sensitive to the many ways that individuals may be affected.

Terrorism can affect entire populations. This may be particularly true of immigrant groups, especially those with large numbers of refugees. Module 4 presents an in-depth look at the population-specific vulnerabilities that may influence a community's reaction.

Phases of Recovery

Much of what has been written about providing disaster mental health services is related to natural disasters. Therefore, the model for providing services and trying to understand the phases people have gone through in the days, weeks, and months following a terrorist attack has been based on crisis counseling for natural disasters (see Table 2–1).

Table 2–1. Phases of Recovery from Natural Disasters

Impact Phase	• Initial shock of the event • Reactions include confusion, disbelief, and worry
Heroic Phase	• High activity concentrated on rescue efforts and evacuation • Community cohesion as people come together to donate goods and services • Temporary suspension of community tensions (e.g., between different racial/ethnic groups) • Anxiety intensified if family members are separated
Honeymoon Phase	• High level of optimism as the community works together • Quality of interaction between relief workers and survivors crucial to perceptions of the total relief effort as well as beliefs about recovery
Inventory Phase	• Survivors recognize the limits of relief • Survivors begin thinking about their futures
Disillusionment Phase	• Survivors realize the reality of their losses • High stress played out through personally destructive acts, family tension, and community division • Potential for hostility between neighbors and among communities • Receiving assistance from relief agencies can be complicated and frustrating • Survivors feel powerless and angry
Reconstruction Phase	• Ongoing • Structural rebuilding • Adapting to lifestyle and environmental changes

As CRP staff members learned, however, there are significant differences between natural and man-made disasters in terms of the impact, recovery, and services that are provided. The disaster, which began September 11, 2001, cannot be characterized as a single event. Rather, it has encompassed a series of terrorist threats and actions designed to provoke widespread fear and anxiety among citizens in Virginia and nationwide. There is greater uncertainty than has been experienced before in the United States, due to the war on terror and the daily media barrage on possible future terrorist activity. The ongoing threat of current and future terrorist activities has led many otherwise healthy people to experience sustained anxiety manifested as fear, anger, and irritability.

The snipers brought back the fear that 9/11 started, which is that the government cannot protect the citizenry of this country. As public safety officials were looking for the snipers and assuring people to go about their regular business, there was also the feeling that they had no idea where they [the snipers] were, or who might be their next victim, and that's the very feeling that 9/11 generated and continues in our society. We still hear about the possibility of more 9/11-like attacks being carried out more than 2 years later.

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The people of the Commonwealth of Virginia confronted a series of traumatic experiences—grief, terror of death, disruption of daily life, anxiety, helplessness, uncertainty, and anger. Virginians have been attempting to cope with 9/11, as well as recovering from a series of traumas since then, such as the sniper attacks that occurred in October 2002.

When the first sniper shooting occurred in Maryland—few paid special attention to it; it was just another unfortunate random shooting. However, as the sniper shootings continued and moved into other parts of the DC metropolitan area and into Virginia, terror spread and intensified throughout the region. The snipers shot people as they pumped gas at filling stations, sat on a bus stop bench, or walked toward the school entrance. As a result, people feared open-space areas. Sporting events and many other outdoor events were cancelled. Lost opportunities, such as high school homecomings, can never be regained. Fear permeated the Washington, DC, area. People were anxious as they went about their daily lives. It took some time to realize that this, too, was terrorism and that it was causing tremendous fear and helplessness. For more information on the impact of the sniper attacks on the region, see below.

People are tired and they have a sense of living under a great deal more stress then they've had to. We've had the roller coaster of events following one after the other. People used to say that when you have a critical event then there's eventually a time when things slow back down. But living in the nation's capitol, in a place which is clearly armed and preparing for war, there's no way to go back, no sense of returning to normalcy.

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The following October 9, 2002, CNN.com story provides more detail about the impact of the sniper attacks in the DC metro area.

'This is like a war zone': Recurring terror in D.C.

(CNN)—First, there was the crushing blow of hijackers ramming a plane into the Pentagon. Then there was the uppercut of anthrax attacks. That bio-terror shut down legislative buildings and post offices and killed two Washington D.C.-area residents.

Now a sniper is on the prowl. Six people are dead. Two more are injured.

Mental health professionals say such recurring terror can leave people in an embattled community such as the Washington environs on psychological ropes.

"I feel like this is a war zone we're living in," one Maryland resident told CNN. "President Bush is talking about fighting Iraq, and we have a war in this country he needs to deal with."

A barrage of stressful events sometimes weakens a person's ability to cope, said Dr. Charles Raison, an assistant professor in mind-body programs in the psychology and behavioral sciences department at the Emory University School of Medicine. People, who may have successfully staved off anxiety after one stressful occurrence, may not be able to withstand repeated terror-inducing situations, he said.

"There is a long of evidence that people who are exposed to one stress after another are more likely to develop stress-related disorders," said Raison, a psychiatrist. A common manifestation, he said would be a sense of fearful dread or horror.

Virginians and all Americans are still experiencing the threat of terrorism. There were many examples from the heroic and honeymoon phases following 9/11, but the Anthrax attack hurled the community back into the impact phase. The war in Iraq and the new threats of terrorism continue to generate fear and impede the recovery process. The ongoing nature of terrorism requires the disaster mental health worker to assess not only the impact of the current incident but past terrorist incidents in order to understand the circumstances in which they will be working.

Each of these events postponed in a lot of people the natural occurrence of mental health problems, especially post-traumatic stress disorders and other trauma disorders which we would expect to occur during the year to 2 years after the initial event. It appears that the timeline has been shifting because each new trauma puts people back to where they were earlier in their psychological recovery.

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Community Resilience Project

Onsite Assessment

Upon arrival at the site, the disaster mental health worker is likely to meet with the setting manager and immediately be tasked with determining who needs help most. During this period, the mental health worker will be expected to set priorities; assess the environment, survivors, and workers; conduct interventions; and obtain closure. Yet, these opportunities and initial contacts at the site may be critical both to minimizing psychological trauma and to fostering resilience. Thus, the importance of conducting a thorough and thoughtful onsite assessment is critical to the immediate and long-term mental health of those affected.

One way to conduct a rapid onsite assessment is to conduct a "defusing." Applied under a slightly different context than the interventions described in Module 3, this term refers to the process of helping through the use of brief conversation. Because the site will likely be somewhat chaotic, defusing as a method of onsite assessment will probably consist of short conversations in passing, perhaps in line for coffee or while eating. Defusing allows the disaster mental health

worker to quickly "work the room" and assess which survivors, responders, or others might need additional support, reassurance, or information. It also provides the opportunity to assess and refer those who might need more in-depth social or mental health services. Finding unobtrusive ways to be in the vicinity of survivors and responders, such as handing out blankets or offering to get someone a soft drink, can help facilitate the defusing process and may also help a victim shift from survival mode to focusing on practical steps to restabilizing.

Disaster mental health workers may practice the following steps:[3]

- **Establish rapport.** Informal socializing is appropriate, such as asking, "Can I get you a soft drink or a bottle of water?" Do not ask for an account of the survivor's experience at this point, and avoid questions or statements that might be interpreted as condescending or trivializing, such as " How are you feeling?" or "Everyone is so lucky to be alive."

- **Conduct assessments.** Assess individuals' ability and willingness to shift from their current focus to social conversation. For example, notice if individuals are so preoccupied with their own practical concerns that they are unable to engage in light conversation with others. Ask open-ended questions related to their concerns, such as "How can I help you while you're waiting for more information?" or "I'm not sure if they're letting people back into the neighborhood, but I'd be glad to see if anyone has more information." During this exchange, evaluate how individuals respond to inquiries and whether they are following the conversation.

- **Gather facts.** Fact-finding can be an efficient means of quickly determining who is most at risk due to exposure to life threat, grotesque and potentially upsetting experiences, or other traumatic stimuli. Questions such as "Where were you when it happened?" and "Were there other people with you?" also are much easier for survivors to answer at this stage than questions asking them to relay their thoughts or feelings.

- **Inquire about thoughts.** Using the description of facts that the survivors have provided, ask probing questions about their associated thoughts, such as "What were your first thoughts when it happened?" "What are you thinking now that the immediate threat is over?" "Is there anything, in particular, that you keep thinking about?"

- **Validate feelings.** Inquiring about feelings at this time is probably not appropriate. Be cautious about asking these types of questions. The defusing in this context is meant only to provide useful information to enable the mental health worker to make a rapid assessment of needs. It serves as a brief intervention that precludes in-depth exploration and ongoing support. Therefore, it is important to avoid questions that might heighten a survivor's sense of vulnerability or cause overwhelming anxiety. Look for opportunities to validate common emotional reactions and concerns, providing assurance by helping the survivor to understand typical reactions to abnormal events and situations. While helping survivors to understand the common course of traumatic reactions will not bring closure to their experience, it may give the survivor a greater sense of control and may help to prevent emotional numbing or dissociation.

[3] Adapted from Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

- **Provide support and reassurance.** Though listed as the last step, providing support through reflective listening, dispensing information, and offering practical help should actually take place throughout the interaction. As the mental health worker moves to closure of the defusing, it is important to assess the survivor's support system to determine if a referral for social or mental health services is necessary. If a strong support system exists, emphasize the value that such social support can have in the recovery process. In addition, members of the CRP staff conveyed the idea that helping survivors recall their successful coping strategies for previously stressful experiences also was enormously helpful.

Working in a Disaster Environment

For a number of reasons, providing mental health services in a disaster environment can be very challenging. It may be difficult to identify a person in charge. There may be many people trying to provide assistance in seemingly uncoordinated efforts. It may be difficult to identify and gain access to those who need help most. In addition, as the response effort expands and the scene unfolds, these factors may be in a constant state of flux. This section provides guidance on how to identify the incident commander, or person in charge, as well as information on the national disaster response framework that helps coordinate large-scale response efforts to events involving mass casualties, such as natural disasters and acts of terrorism.

Declaring a National Disaster[4]

When the President declares a major disaster or an emergency, immediate notification is made to the Governor, appropriate Members of Congress, and federal departments or agencies. At that time, the President appoints a Federal Emergency Management Agency (FEMA) or other federal official as the Federal Coordinating Officer (FCO), and the Governor appoints a State Coordinating Officer (SCO). The immediate concern of the FCO and SCO after a declaration is to make an initial appraisal of the types of relief most urgently needed. The FCO coordinates all federal disaster assistance programs to ensure their maximum effectiveness and takes appropriate action to help affected citizens and public officials obtain the assistance to which they are entitled. This process is outlined on the following page.

[4] Federal Emergency Management Agency. FEMA 262: A guide to federal aid in disasters. Washington, DC, June 1997.

Disaster Declaration Process

- Incident occurs.
- Local government responds and contacts the state, if necessary.
- State government responds.
- If state resources are unable to provide adequate response, the Governor requests that the President declare a major disaster/emergency.
- The FEMA Regional Director confirms the Governor's findings.
- Regional findings and recommendations are given to the President.
- The President declares a major disaster/emergency, if necessary.
- The FEMA Associate Director appoints the FCO and designates areas eligible for federal assistance.
- The disaster program is implemented.

Coordinating a Response[5]

In the United States, a national response to large-scale traumatic events, such as natural disasters and acts of terrorism, is conducted through a coordinated approach involving local, state, and federal agencies. The Federal Response Plan (FRP) is the starting point from which all coordination decisions are made. The FRP describes how the administrators of 27 federal departments and agencies call up resources to support state and local response efforts. In particular, it details how states request and receive federal aid.

Once federal aid is approved, it is provided for specific functions that fall under 12 Emergency Support Functions (ESF), including firefighting, health and medical services, and mass care. Each of these functions is headed by an agency that may act as the lead coordinator at a terrorism site. Mental health services fall under ESF#8, Health and Medical Services, headed by the Department of Health and Human Services (DHHS). However, other agencies may lead the effort, depending on the nature of the event. The lead agency is often unclear until officially announced.

[5] Federal Emergency Management Agency. 9230-1-PL: Federal response plan, interim. Washington, DC, January 2003.

The table below lists each function and their lead agency.

Table 2–2. Emergency Support Functions and Lead Agencies

Emergency Support Function	Lead Agency
ESF #1—Transportation	Department of Transportation
ESF #2—Communications	National Communications System
ESF #3—Public Works and Engineering	U.S. Army Corps of Engineers, Department of Defense
ESF #4—Firefighting	U.S. Forest Service, Department of Agriculture
ESF #5—Information and Planning	Federal Emergency Management Agency
ESF #6—Mass Care	American Red Cross
ESF #7—Resource Support	General Services Administration
ESF #8— Health and Medical Services	Department of Health and Human Services
ESF #9—Urban Search and Rescue	Federal Emergency Management Agency
ESF #10—Hazardous Materials	Environmental Protection Agency
ESF #11—Food	Food and Nutrition Service, Department of Agriculture
ESF #12—Energy	Department of Energy

Establishing and Following the Leader

As a result of the preparedness planning described in Modules 1 and 7, the disaster mental health worker may be well-positioned within his or her local community and will have made the appropriate contacts within the local Emergency Operations Center (EOC) to ensure access to the site of the event. In addition, having introduced oneself to the appropriate points of contact before a disaster, and perhaps even integrating him- or herself into the local EOC, the mental health worker may gain access to copies of the state's initial assessment of the situation, as well as to the site itself to provide services.

The importance of having memoranda of understanding regarding operations is crucial in being able to sit at the table with an understanding of who is responsible for what. More importantly, what we were able to do was pull together a coalition of private and nonprofit agencies, and we kept each other apprised of who was providing what…and we could see that there was a lot of duplication of effort. So, while it felt chaotic in the beginning, because of the spirit of volunteerism and because so many people were very interested in doing the right thing in the right way, what could have been very chaotic turned out to be a relatively smooth operation.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

Because of the confusion and panic that characteristically result at the site of a terrorist attack, finding and reporting to the person in charge may be difficult, regardless of the contacts made in advance. However, if the event is suspected of being an act of terrorism, assume that a federal agency is coordinating the response and that the local EOC will be coordinating response efforts with the federal authorities. Prior to reporting for duty onsite, the local EOC should be contacted to assist the

mental health worker in identifying the appropriate authority in charge; that is, the person to whom he or she should report upon his or her arrival.

Working Alongside Others

It is also important to be aware of the other responders who may be present onsite. Some will perform very specific tasks, such as searching for survivors, driving ambulances, or directing traffic. Others will provide more general assistance, such as calming crowds and handing out supplies. Whether their roles are well-defined or not, chances are that the disaster mental health worker will work alongside and coordinate services with them. The table below provides an idea of who those other service providers might be.

In a given event, one never quite knows which institutions and which organizations will be involved in the response. In the 9/11 Pentagon response, for example, we had the military, so we had the federal government. We also had local jurisdictions as well as state jurisdictions. So, in the Pentagon disaster, each of those institutions had their own organizational rules and regulations for how to operate.

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Table 2–3. Who Might Be Found Onsite

Local Response Public Agencies	• Fire and rescue department • Law enforcement • Local emergency management • Public works • Emergency medical services • Hospitals • Local officials • Survivor services • Human services
Local Response Private Agencies and Civilians	• American Red Cross • Salvation Army • Unmet Needs Committee • Community action groups • Good Samaritans • Clergy • Media • Employee assistance programs • Funeral homes

State Response	• State emergency management • State medical examiner's office • Public works • National Guard • Highway patrol • Public health • Governor's office • State attorney's office • State crime survivor compensation program • Consumer Protection Agency
***Federal Response**	• Federal Bureau of Investigation (FBI) • Bureau of Alcohol, Tobacco, and Firearms (ATF) • Office for Victims of Crime (OVC) • Federal Emergency Management Agency (FEMA) • Public Health Service (PHS) • Centers for Disease Control and Prevention (CDC) • Center for Mental Health Services (CMHS) • General Services Administration (GSA) • Small Business Administration (SBA) • Department of Veterans Affairs (VA)

*Note that many agencies are from a larger unit. CMHS and PHS, for example, are part of DHHS. Onsite, workers will probably identify themselves as being from CMHS or PHS, not DHHS.

Recognize that even when disaster mental health workers arrive a few minutes or hours after the event, there will likely be others already on the scene who are providing mental health support. Often, bystanders—with or without professional training—will attend to victims in a spontaneous way. Look for these "natural helpers" and join their efforts.[6]

The Role of the Disaster Mental Health Worker

Being Flexible and Resourceful

Every moment at the site provides a valuable opportunity for mental health workers to simply connect with someone who has been affected by the disaster. When approaching survivors, they should keep in mind that people may be preoccupied initially with basic life needs—where they will sleep tonight or why a child's babysitter doesn't answer the phone. Some may be unable or unwilling to explore their feelings and reactions. For more information on approaching individuals and appropriate interventions, see Module 3.

During the development of this training, CRP staff members were interviewed about the roles they played during the aftermath of 9/11, and asked what guidance they would provide other mental health workers who were preparing to provide services to survivors at the site of a terrorist attack. They cautioned that the disaster mental health worker should be prepared for the

[6] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

possibility of being met with an unwelcome reception. They explained that, just as mental health stigmas are common in some communities, the presence of a mental health worker in an obvious mental health capacity could make some people uncomfortable, unwilling to interact, and perhaps even more distressed. They shared further that, during the response to the 9/11 attack on the Pentagon, several mental health workers found that many military personnel who were present at the scene were reluctant to talk with them. One mental health worker, however, found a way to get past this barrier. She identified a gatekeeper—the military chaplain—who was onsite providing services to the military staff. She began working with him and, in doing so, found a much warmer reception from other military personnel because of that affiliation.

Self-Assessment

Aside from the mass casualties that may be terribly upsetting, the mental health worker may also be surprised at his or her own reaction to the act of terrorism. Mental health workers are not immune to the same feelings of shock, fear, and insecurity that others at the site will be experiencing. Should the disaster mental health worker go into the field in the immediate aftermath, it is important to keep in mind that continual self-assessment and processing with coworkers is key to maintaining mental health. See Module 6 for more information on self-care.

I don't think all of us are suited to being actively involved in disaster work. So, people have to honestly assess themselves and determine if they like to be in a hectic, non-structured setting, not knowing exactly what [their] duties are going to be. One needs to be spontaneous, reacting quickly to the needs that are presented. One also needs to be a person that can really go with the flow and also do some things that are not what a therapist would do. There are roles after disasters, such as counseling victims and secondary victims in the days, weeks, and months afterwards. You don't have to actually go to the scene to be a valuable part of what the community needs to recover.

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Summary

The impact of terrorism is felt far beyond those directly affected by the event. Thus, providing effective mental health services to survivors requires the ability to recognize the extent of terrorism's reach into a community and to respond appropriately for the mental health of individuals and the community. Responding appropriately in the early stages following terrorism primarily involves being available, supportive, and reassuring. The challenge for disaster mental health workers who have been trained to deal with pathological dysfunction is to take a supportive role in a nonclinical setting. This requires the ability to conduct a rapid onsite assessment and determine which of the many roles a disaster mental health worker may play. It also requires an understanding of the pattern of phases of recovery that may follow a catastrophic event, and recognizing that reactions may differ depending on variables such as the nature of the mass trauma event. Having a general familiarity with the Federal Response System and how to navigate it to increase access is also key in providing effective mental health services.

You can be involved in the beginning after an incident, when things are very intense at ground zero, in helping the first responders and others deal with their difficulties and, of course, the victim's families, the people who are at the site, and so forth. But mental health practitioners need to allow themselves to decide if that's the way they can best contribute. There are many other ways a mental health practitioner can respond. They can provide ongoing services, supportive services, grief services. They can decide to specialize in PTSD and other kinds of disorders that might require services 6 months, a year, or longer after the event, but they would still be very much a part of the provision of services.

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Additional Resources

Appendix A: Weapons of Mass Destruction 101.

Are you ready? A guide to citizen preparedness, Federal Emergency Management Agency, http://www.fema.gov/areyouready/

CDC Public Health Emergency Preparedness and Response, http://www.bt.cdc.gov/

Unit 8: "Terrorism and CERT," community emergency response team instructor guide, Federal Emergency Management Agency, Emergency Management Institute, http://www.training.fema.gov/emiweb/cert/mtrls.asp

U.S. Department of Homeland Security, http://www.ready.gov/get_informed.html

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.